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ABSTRACT

This group of papers presents the conference reports and discussion topics of the American Orthopsychiatric Association annual meeting. The conference topic was "Dilemma of the Therapist; Practice and Values in a Changing Society." Reports and discussions focused on examining ethical concerns and the dilemmas they pose for therapeutic practice; they specifically dealt with the following topics: (1) changing definitions of sexuality, (2) the variety of new therapeutic modalities and their philosophical underpinnings, (3) the appropriateness of offering mental health services in certain institutional settings, (4) the influence of changed delivery systems on therapeutic work, (5) the influence of changing life styles and family patterns, (6) the influence of socioeconomic class on practice, and (7) the impact made by ethnic struggles on therapeutic work. The list of discussion topics clearly suggests how the external world interfaces with psychological concerns and adaptation--two interdependent, reciprocal, and inseparable spheres of complex human existence. (Author/PC)

ED 095470

April 10, 1974

Welcome; I am Shirley Cooper, your chairperson for this session on the Mentality and Mechanics of Social Control.

The term Watergate will, no doubt, become part of the lexicon of the American language. It is without question not only a state of affairs but also a state of mind.

Even now when we have been exhorted by President Nixon to set aside "our preoccupations with Watergate," this state of mind -- Watergate -- repeatedly asserts itself. One of its chief architects, H. R. Haldeman, called upon his business audience on April 3, 1974, to resist judgment about our President, insisting that all the facts were not yet known. On query, he added and I quote, "an awful lot of information and knowledge is being made public that in my opinion, and I know in the President's opinion, should better not be made public in the interest of the nation."

When asked further if he, thus, meant that Americans could not handle the truth, he replied, and I quote again, "The American people don't have the means by which to determine the entire truth in ample or adequate perspective." Americans, he added, could have neither the information nor the judgment to decide about such critical issues as "the Bay of Pigs, the Cuban missile crisis, the Yalta Conference, or the Vietnam bombing halt in 1968."

This arrogant, "Big Brother," Watergate mentality is still offered after the vast and long-resisted exposures which have so chilled our minds and hearts -- so late as April 3, 1974.

Watergates can flourish so long as aggregates of power grow secretly so large as to resist containment, balance, and open question.

We have only recently learned from the Congressional Special Committee on the termination of the National Emergency that the President's power currently includes legal authority at this very moment to:

" Place practically any person in the United States in military detention for up to one year.
" Dispatch U.S. military forces to any nation in the world 'he considers it advisable to assist in the interest of national defense.'
" Seize and control all transportation and communications, including the closing down of any radio or television station or network or newspaper wire service.
" Institute martial law.
" Seize properties and commodities.
" Organize and control the means of production.
" Restrict travel, and, in the words of a Senate study, 'in a plethora of ways, control the lives of all American citizens.'" (San Francisco Chronicle, April 7, 1974.)

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Quoting from the Chronicle of April 7, 1974, we learn that:

> "Although it has become a popular pastime for Congress to lament the erosion of its powers, it was Congress that enacted the hundreds of statutes that surrendered more and more power to the executive branch in what Cornelius P. Cotter, a University of Wisconsin political scientist, has called a 'surrealistic nightmare of eternal emergencies.'"

It would be easy indeed to turn our eye toward the outside enemy and to lament his evil. However, the oft-repeated comment that we have met the enemy and he is us applies.

Watergates are all about us and in us, cloaked in many guises and many forms. We may not turn away from these powerful and ubiquitous forces within us -- forces which collectively assent and coalesce with public behaviors to create fertile soil in which Watergates take root and flourish.

These forces are hardly new to any behavioral or social scientist. They may bear repeating briefly:

-- The fear of dissent, carrying with it potential scorn and rejection;

-- The opposing hunger for acceptance which promotes assent and consent even when doubts and disapproval nag and discomfort;

-- The hunger for affiliation and connection which press for conformity, even at the cost of yielding independent judgment and the integrity of our own experience;

-- The forces that push for closure and certainty over tolerance for ambiguity, fashion over judgment, elitism and exceptionalism over equality of opportunity;

-- Forces that seek relief from feelings of powerlessness, though such relief may exact apathy and the constriction of our freedoms.

Our personal and professional as well as public lives are at stake. If we fail to grasp the meaning of Watergate, we are in danger not only of losing liberty -- we stand in danger of losing touch with personal judgment, a sense of the real, the valued and the proper. We do not simply lose freedom, though surely that is loss enough -- but, more, we are in danger of yielding our dreams and dulling our reach.

It is in this sense that we meet today to examine our own work in order to explore how we, too, may function wittingly or unwittingly -- asserting our right and our science to understand better and know more than our fellow citizens can comprehend.

In the spirit of open inquiry, we will in this session search, assess and review where we are in our work, so that we may learn the limits and dangers of our technology, a technology now sufficiently advanced that it may, if improperly used, control the minds of men.

Let me turn now to our first speaker.

1. Arlene Daniels, Ph.D. -- Psychotherapy in the Military

2. Marc Pilisuk, Ph.D. -- The Philosophy of Social Control and Mental Health

3. Edward Opton, Jr., Ph.D. -- Social Control and Mental Health

4. Leon Epstein, M.D. and Henry Lennard, M.D. -- Use and Abuse of Psychotropic Drugs

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Introduction - Ortho Institute

Dilemma of the Therapist: Practice and Values in a Changing Society

Shirley Cooper, M.S. and David Orzech, Ph.D.

We have repeatedly been reminded throughout the ages by the great thinkers that there are no eternal truths. Making this point, Wheelis comments that "absolute truth is a fiction--a longing of the heart not to be had by man."* He adds: "...eternal verities prove both transient and untrue...Since man became a historical being each age has been able to recognize the certainties in the past as mistaken, often as absurd."**

Thomas Szasz,*** illustrating this idea, tells us that a prominent physician in 1851 claimed to have identified two new diseases peculiar to "the Negro race." One of these he called Drapetomonia--from the Greek drapetes--meaning the fact of absconding and mania--known to all of you. Put together, this new mental illness--peculiar to slaves--was manifested by their running away. The second illness was called dysaethesia aetheiopis --popularly called by overseers, rascality. This illness was manifest in slaves' neglect of their work or their unwillingness to work altogether.

Recognition of the inherent limitations of certainty has always been demonstrable, but it takes on particular difficulty and urgency in periods of rapid social and intellectual change. No one can dispute that this is such a time. Social and ethical certainties vanish into doubt and confusion while, simultaneously, revolutionary views are offered with intense conviction. Change, sometimes propelled by confrontation, creates tensions for professionals, since it demands a review of accepted assumptions and professional definition. Unfortunately, we seem more inclined to advocacy and polemic--the free exchange of ideas and the co-existence of complementary approaches to human problems are hard to retain under the sharpened imperative of change. Pressure for change is couched in such phrases as "innovation," "meaningful response to the community," "relevance," and "serving the unserved." On the one hand, experts are dethroned by the spirit of new egalitarianism, while on the other they seek to expand their influence to fields bordering mental health.

Sharp questions confront the field of mental health: Is mental health a definable field at all, or so intertwined with other aspects of human experience that no boundaries can be set? Are mental health professionals

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* Wheelis, End of Modern Age, Basic Books, pgs. 114-5, 1971.

** op cit, pgs. 182-3.

*** Szasz, The Same Slave, American Journal of Psychotherapy, Vol. 25, April, 1971.

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of value or have they impeded progress and service to those in need? Have they outweighed their usefulness by obstinate clinging to tradition and elitist privilege, blocking entry of others into their ranks? Is preoccupation with individualism and individual freedom a luxury which obstructs justice for the disadvantaged who must first win their freedom in groups? Has concern for intrapsychic processes retarded the development of important social action? Do those who practice in slow and often tedious ways make service to the many impossible? Are such ways defensible? Since so little is known about effectiveness, are extended training programs for mental health professionals justifiable?

We may not have complete or precise answers to these real and plaguing questions. Yet, if we opt for facile responses because we are overwhelmed by the enormity of the problems, we may hold out false hope and promise.

Yet, forsaking certainty, we face the temptation to view all ethical propositions as culturally relative, transient and all equally legitimate. As indicated, such temptations promote partisan and rigid polarities on the one hand or a position of nihilism on the other. The former has led to vast splintering of our society into ideological camps advocating particular philosophies with evangelical fervor. A case in point was a recent offering by a behavioral modification therapist who polemically destroyed psychodynamic theory and practice in a book entitled Trick or Treatment (How and When Psychotherapy Fails, Richard B. Stuart, Research Press, Champaign, Illinois, 1970). The latter nihilist position has been most evident in the slogans developed in the '60's: "Do your own thing" and "That's not my bag."

In our field, this kind of either/or thinking has been expressed in the long-standing argument about whether human psychological problems are best understood as illness and pathology or perfectly understandable and acceptable responses to external social conditions. The inside-outside battle continues to rage.

The raging dispute between the "medical model" on the one hand and social pathology on the other has been with us, stridently influencing our therapeutic attitudes, values and techniques for more than a decade (to say nothing of the variety of meanings one can understand about the "medical model"). At times, these arguments lose all semblance of a scientific core and move clearly into the domain of political polemics.

Bayard Rustin warns of the danger of such politicization:

> It is essential that we make an important distinction between issues of politics and problems in psychology. We should see this as a distinction between what we do in order to influence the political and economic relations in the society and what, in a more personal way, we do to achieve self-knowledge and identity. Now I do not think that these are hard and fast categories that totally exclude one another. A just society certainly encourages a health psychology, and individuals

> can find personal fulfillment through political involvement. But I think we must make this distinction, because in periods of great social upheaval--and we are living through such a period--there is a tendency to politicize all things, including scholarship, art, friendship and love. The most extreme form of this total politicization is totalitarianism, a state we have not yet reached.

Nevertheless, it would be absurd to maintain that we work antiseptically free of value considerations. Our field touches on all major ethical concerns while we ourselves--the major tool in our work--have highly elaborate value systems.

It seems clear to us that ethical dilemmas in psychological work cannot simply be wished away--either by assigning them to another level of reality--economics or politics--nor can they be dealt with by an insistence that they are irrelevant to our activities.

These are the overriding considerations of our institute. We will be examining, for the next day and a half, ethical concerns as these pose dilemmas for our therapeutic attitudes and practice.

Specifically, we will be considering:

- the changing definitions of sexuality;
- the variety of new therapeutic modalities and their philosophical underpinnings;
- the appropriateness of offering mental health services in certain institutional settings;
- the changing role of women;
- the influence of changed delivery systems on our therapeutic work;
- the influence of changing life styles and family patterns;
- the influence of socioeconomic class upon practice; and
- of course, the enormous impact made by ethnic struggles upon our work.

The very listing of the issues we will be discussing clearly suggests how the external world interfaces with psychological concerns and adaptation--two interdependent, reciprocal and inseparable spheres of complex human life.

With this, then, as background, may I proceed immediately to tell you:

1) of our general overview plan for our institute, and

2) to introduce our first presenter of the morning.

Annual Meeting of the American Orthopsychiatric Association

April 8-12, 1974, San Francisco

Title: Social Changes, Political Radicalism, and the Homogenization of Psychotherapy

Author: Donald P. Cliggett, Ph.D., Director, Internship Program in Clinic Psychology, Mt. Zion Hospital and Medical Center, San Francisco, California

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1600 Divisadero Street
San Francisco, California 94115

Time: Monday, April 8 9:00 a.m. to 5:00 p.m.
Tuesday, April 9 9:00 a.m. to 12:00 noon

Place: Hilton Hotel

Program: Institute: Dilemma of the Therapist-Practice and Values in a Changing Society

Co-Moderators and Organizers: Shirley Cooper, David Orzech, San Francisco State University, California

Participants: Donald P. Cliggett, Nanette Heiman, Mt. Zion Hospital and Medical Center, San Francisco, California; Ilse K. Jawetz, San Francisco, California, David Orzech, San Francisco State University, California; William D. Pierce, Westside Community Mental Health Center, Calif; Frank Smith, Prisoners Union

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Over the period of the past decade we have witnessed in the field of mental health a truly astounding proliferation of new therapeutic and quasi-therapeutic approaches and related changes in social values and sexual mores. Both in terms of the suddeness of this change and the speed with which it spread it might be likened, by partisans of one or another persuasion, to either a plague or a revolution, perhaps a flowering of Consciousness III or a reversion to a primal hedonism.

From the work of Kurt Lewin in group dynamics during World War II and Kurt Goldstein and Frederick Perls, especially in the latter's revision of the work of Wilhelm Reich into a new "Gestalt therapy," we have seen emerge the training-in-sensitivity and encounter groups, the growth centers, the weekend and nude marathons, sensory and body awareness groups and so-called centers for sexual "intimacy." The leaders of these groups range from accomplished professionals with extensive training to individuals who at best have only a personal aptitude for such work, and perhaps a weekend of experience as a group member themselves. During the same period we have also seen dramatic changes in social values and sexual mores. We all either have heard about or have first-hand knowledge of professional colleagues, or friends and acquaintances accomplished in other fields, who have suddenly abandoned traditional values and responsibilities towards their work and families, to pursue an entirely new and presumably more creative life-style. Similarly we are all familiar from one source or another, with the "new sexuality," the reported increase in either freedom or compulsion to engage in more frequent sexual activity in both the younger and older generations. The increase in popularity of non-traditional living arrangements evident for example in more and more young couples living together sometimes for years and sometimes even raising children but choosing not to marry, the growth and popularity of communal affiliations, and such things as open marriage and group sex, are further indications of a striking change in the traditional attitudes towards work and pleasure.

In attempting to arrive at some perspective on these rapid changes it may be helpful first to try to identify some of the forces which may have helped to bring them about, then trace their influence on the mental health enterprise generally and in the process illustrate some of the dilemmas they present to the professional work of the psychotherapist.

Fifteen years ago a book was published entitled, Action for Mental Health. This was the report of the Joint Commission on Mental Illness and Health which advocated sweeping changes intended to bring about a new availability of mental health services to that portion of the populace, the lower end of the socio-economic ladder, which had not had access to them before. In the catch-phrase of that era, it was to bring this group into the "mainstream" of mental health care.

Among the many changes advocated in the report was the wider psychotherapeutic use of all medical and non-medical mental health professionals who had appropriate training, and to the extension of their skills through a program of training others referred to in the report as Mental Health Counselors. These were individuals "untrained or partially trained in mental health principles and practices -- clergymen, family physicians, teachers, probation officers, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, county farm agents, and others..." In the words of the report, "With a moderate amount of training through short courses and consultation on the job, such persons can be fully equipped (emphasis added) with an additional skill as mental health counselors."

Other portions of the report stressed the importance of full professional training and that services and training be provided only "under the auspices of recognized mental health agencies." However, like the proverbial camel who because of its anatomical paradoxes could have been created only by a committee, the Report of the Commission seemed also to be lacking in internal harmony and consistency at least on this issue. Thus the report and the subsequent Community Mental Health Centers legislation it generated not only brought

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about a revolution in the availability of quality mental health care to the disadvantaged, but in its authoritative endorsement of less-than-professional training for providers of mental health services, it not only set the stage for the training of helpful para-professionals, but inadvertently undermined professional standards and promoted a misplaced and specious anti-elitism and egalitarianism within the mental health field which tends to comprise the very quality of that "main stream" care that the Commission hoped to provide.

This trend was given further impetus by the successful work of Margaret Rioch at NIMH in the training of housewives as psychotherapists and by the funding policies of NIMH which in recent years have given priority for new funding to the training of para-professionals and innovative programs, without sufficient attention, in my view, to safeguards necessary to maintain quality of care. It has even been reported, off-the-record, that in the interests of maximizing innovation there has been serious consideration given within NIMH to the possibility of openly opposing the current practice of licensing mental health practitioners. It is not surprising then that we see in some circles the popularizing of the paradoxical view that it takes less and less training to deal with some of the most complex problems in the field of mental health.

Without doubt the most powerful socio-cultural and political force within the social matrix of the early and mid-Sixties was the Civil Rights Movement and the Associated "revolution of rising expectations." The Community Mental Health Centers, staffed as they are with professionals who traditionally tend to hold liberal political and progressive social views, and located as they often are in the central cities close to the minority populations they serve, often came to represent both the most hopeful promise of social relief for the disadvantaged, as well as the most immediate representation of "establishment" resistance to that change. Mental Health professionals who had long viewed themselves as an exception to the political conservatism of professionals in many other fields now found themselves under heavy criticism for using their diagnostic and therapeutic skills merely to "label the victim" of social and economic problems instead of taking the necessary community action to eliminate the problems themselves. The para-professional and indigenous worker, with his intimate knowledge of the community was much better informed and more aware of the oppressive community realities and seemed more sympathetic and helpful than the professional who offered only some promise of relief from inner stresses. Thus the utility of the therapist's psychological knowledge and clinical expertise was seriously challenged by the disparity between the seemingly minor intra-psychic problems that he could offer some help with, and the monumental and sometimes immutable reality problems of his patient's every-day lives. It often seemed to the therapist in such settings that he had abundant knowledge about something of no consequence, and about the things that did seem to matter he was a rank amateur and a political babe-in-the woods. Worse than that, if he attempted to practice what he had been trained to do and seemed unwilling to expose his political impotence by turning his position into a platform for social action, he ran the risk of appearing to have abandoned the minorities he was working for to become a guardian of the oppressive "establishment" status quo. In the rhetoric of the period, if in his professional work, he wasn't part of the solution, he was part of the problem.

During the same period there was a concurrent development within some factions of the Community Mental Health scene which held the view that the psychology of the white middle class on which the professional's expertise had been built had little or no application to the problems of minorities. Because they had lived so long with the multiple psychic traumata of ghetto life minorities were said to have developed a special immunity to certain stresses, such that the order and hierarchy of their emotional needs were essentially different and not amenable to understanding through customary mental health principles and concepts. Thus the professional psychotherapist became twice-blessed with incompetence.

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The period of the middle and late Sixties brought with it another major social movement with wide-spread consequences, this time largely within the white middle-class intelligentsia. The growing disenchantment of middle class youth with the apparent spiritual barrenness of their affluent parents' devotion to the work ethic and material acquisitiveness made them particularly susceptible to the sensory blandishments of Timothy Leary's invitation to "Drop out, turn on, and tune in." So we had the birth of the Flower Children and the emergence of the psychedelic drug ethos which glorified the drug-induced withdrawal from reality into an all absorbing subjective fusion with sensory experience. The professional therapist was now challenged on his own home ground. Whatever insight he could offer by means of exploration into the world of inner life and subjective self-awareness was merely a plodding hum-drum excursion which paled by comparison with the cosmic awareness achieved on the acid trips of his patients. But once again in the eyes of those he attempted to help he was often viewed as the guardian of establishment values attempting to seduce his charges back into the enslavement of the work ethic and the empty middle class values of their parents. In this instance, however, he was <u>too</u> reality-bound and too indifferent to <u>inner</u> experience and to the promise of expanded consciousness offered by the psychedelic traveler. Yet the therapeutic task was again one of maintaining a focus on the conflicts and fears which induced withdrawal while neither endorsing the values the patient rejected nor identifying with his psychic rebellion against them. Despite the sympathy one might have for the acuity of the patient's perception of the shallowness of many middle class values and of the work ethic as a philosophy of life the task was not to join the patient in rebellion against them but to help resolve the inner conflicts which produced only a retreat from any realistic struggle to overcome them.

The late Sixties also saw the growing public revulsion with the violence and barbarities of the war in Southeast Asia and with the amoral dedication of our massive industrial and managerial technology to what at times approached a strategy of extermination. The growing disillusionment with a social order that presumably esteemed the life of reason and the worth and dignity of the individual yet pursued such a course of military action with such cool technical and scientific proficiency, added to a growing public suspicion of any professional discipline which rested heavily on the assumption of the primacy of reason in the management of human affairs. The growing ecological blight and the pollution of the environment also bore testimony to the varied ways in which a growth and production-oriented society could turn knowledge, and technological skills into quantitative wealth but qualitative impoverishment. There was also, especially among the young, a growing disenchantment with the categorical and hierarchical arrangements in the social order, and a related rejection <u>not</u> only of the more arbitrary and artificial signs of social status, but of any enterprise which implied elitism in human affairs, even or perhaps especially if presumably based on so-called "linear" reasoning or expert knowledge. Thus the diagnosis and treatment of emotional problems was seen as an elitist relationship involving an assumed but specious superiority of one person over another, a sure sign of Consciousness II, while the emerging ethos of Consciousness III was that of a total and universal egalitarianism in which no person was in any way superior to another or entitled to impose his view on anyone else. In this shift away from rationalism there was a compensatory emphasis on feeling and emotional experience for its own sake and a dismissal of any need to understand. The new therapies could then have widespread appeal to the extent that they could quite consciously ignore the past, be indifferent to the future, emphasize the here-and-now, glorify dramatic emotional expression and be practiced by anyone because all people are equal.

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Because of the intensity of emotional experience that such therapies offer they seem also to promise a welcome antidote to those members of the established middle class who feel alienated by the emotional blandness of their everyday routine existence, and the status-consciousness of their upwardly mobile life-pattern. Some of the new groups not only offer instant-intimacy but also unconditional "love," mutuality, and acceptance -- if only for a weekend.

Another factor which contributes not only to the diversity of the therapeutic scene but to its confusion as well, is the self-conscious eclecticism of many graduate training programs for mental health professionals, perhaps especially those in clinical psychology. Appropriately in the academic tradition of the university these programs attempt to present to the new student an informed picture of the theory and practice of some of the major approaches to psychotherapy, for the purpose of an objective scientific examination of the basic assumptions and the major advantages and shortcomings of the various schools. In the process, however, many university programs inadvertently, and some quite deliberately, promote a therapeutic eclecticism not as a scientific attitude but as a professional ideal. Worse yet they seem to encourage in young graduate students the supercilious or contemptuous view of clinical theory which assumes that there is so little to learn that all of it can easily be accomodated in a few courses and a couple of practicums. The alternative and more grandiose notion that they sometimes promote is that although the theory and practice in each school is indeed complex, the capable clinician, perhaps even by the time he completes his doctorate, should be sufficiently informed and skilled to be able to readily and rapidly shift from one approach to another, not only with different patients but even with the same patient and perhaps even within a given therapeutic hour. This phenomenon might be characterized as the ideal of the hyphenated or homogenized psychotherapist, the professional who proudly describes his approach, for example, as a combination of psychoanalytic, Gestalt, Rogerian, Rolfian and a bit of Primal Scream thrown in. If the universities themselves also promote such professional dilettantism then it is not surprising that ours seems to be an age of do-it-yourself psychologizing, and the self-appointed psychotherapist.

The most recent challenges to the implicit values of the dynamically and especially the analytically-oriented therapist are those mounted by the women's and "gay" liberation movements. In these instances, however, there is a much larger intellectual ingredient to these movements in that they openly challenge specific elements of the theory by which the therapist practices. Yet there is still the implicit charge of the radical therapist that traditional psychotherapy with its interpretations of conflicts, is merely a diversion from the real issues, that the true task of the therapist should be to help patients fight their economic, social or political oppression. That there may be individual (and intrapsychic) solutions to what radical movements regard as purely social dilemmas is the therapeutic stance which such groups cannot accept.

Up to this point we have reviewed some of the important social forces in the last decade the impact they have had on the mental health establishment and the challenges they present to the practicing psychotherapist of a dynamic or analytic persuasion. It may be valuable also to briefly identify some of the parameters of the psychotherapy itself which may magnify the therapist's sense of inner conflict about his own technique. We have already alluded to such analytic values as the importance of personal history and early genesis of psychological problems, the appropriate assessment of inner versus outer realities in determining the proper arena for the resolution of problems, the assessment or diagnostic point-of-view itself, and the assumption of rational understanding as the basis for conflict-resolution. Finally, there are those aspects of the treatment which are a function of the values and self-image of the therapist himself. Dynamic analytical

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psychotherapy has its own revolutionary history and tradition. While its most revolutionary foundations consist of Freud's discovery of the unconscious and the role of infantile sexuality in human experience, there was also the popular revolution it generated against Victorian sexual mores and prohibitions. For several decades analytic practitioners were considered social revolutionaries in their own right and this tradition seems to be deeply embedded in the Mental Health Movement generally. For these and other reasons many therapists view themselves as representing the intellectual cutting-edge of any youthful movement for significant social reform. However, in their personal enthusiasm for sometimes rapid social change, their therapeutic practice may fall victim to their own vanity when they turn themselves and their psychotherapy into symbols or vehicles of social or political advocacy. While it is understandable that the young and inexperienced therapist may have particular difficulty in separating his own personal identity and values from his newly emerging professional ones, it appears that even the more experienced professional is sometimes seduced by his own narcissistic need for youthful revolutionary fervor. We have all had some exposure to the type. One can read the tides and cross-currents of political and social change not only from the rapid and dramatic alterations in his dress and appearance, but in his psychotherapy as well. He is the perpetually "hip", "cool," or "with-it" psychotherapist. During the era of the Flower-Children and the long-haired, bearded, "hippie", he became the therapist-turned "Guru", complete with sandals, beard, and prayer beads, who felt he had to be as knowledgeable about Acapulco Gold and the Macrobiotic diet as some of his pot-smoking patients.

During the hey-day of the Civil Rights Sixties, the "uniform" might be dashiki-with-Afro (if his hair was equal to the challenge) and his therapy might be heavily larded with the lingo of the streets. During the current sexual revolution, he may feel obliged to appear even more "emancipated" than some of his sexually preoccupied patients, both within as well as outside the consulting room, and demonstrate in one way or another his personal knowledge of open marriage, group sex or the occasional orgy. And of course it is always done in the name of creative innovation, and any suggestion that instead it may be a matter of mutual political or sexual seduction of patient and therapist is dismissed as Nineteenth-century Freudianism.

In this rather brief and sketchy overview of the past decade of trials and tribulations of psychotherapy and the psychotherapist, we have had more to say about some of the social sources of the therapist's dilemmas than about their solution. But in looking for "answers" it appears that one of the more promising points-of-departure in starting the search, may lie within the therapist himself and in his willingness to examine the role of his own personal values in the clouding of his therapeutic vision.

Dilemmas in Mental Health: The View from the University

David Orzech, Ph.D.
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I would like to talk about the ways in which current dilemmas facing the field of mental health find expression in teaching our students clinical practice in today's graduate schools. This vantage point affords us, I believe, a particularly useful perspective for at least 2 reasons: first, it has traditionally been one of the functions of the University to encourage examination of various and conflicting points of view. While the University indeed prides itself on this objectivity and neutrality, practitioners in the field setting, by their very commitment to service, may be less patient with such ongoing, unending scrutiny. But more importantly for our purposes: In the process of learning to become professionals, students characteristically go through a "Sturm und Drang" not unlike that experienced by adolescents in our culture; like adolescents, they normatively engage in intense soul-searching, in rebellious and ambivalent challenging of accepted mores. Such persistent questioning may magnify (and thus shed some light on) the discontents in our field today.

We know of course that the business of entering a profession is a difficult process at best, involving not only acquisition of highly complex cognitive skills and competencies, but also the learning of a whole set of experiential, affective behaviors. Even under the most benign circumstances this learning occurs only slowly and disjunctively, with synthesis and integration only apparent after some internal struggle and conflict.

My thesis here is that this process is currently even more difficult, because of a number of reasons of which I would highlight three: 1) the emergence of multiple value systems, 2) the knowledge explosion and, 3) a particular case of the above, the multiplicity of competing treatment techniques.

Let me start out by presenting a recent vignette from the classroom. A student presents the following material on a client: * * Michael is a young man in his early 20's, a third-generation Japanese from an upper-middle class family. An "A" student in Engineering at a major University, he appears rather conservative and old-fashioned in both dress and manner, curiously out of step with the preponderant free student style. He lives at home. Michael is called in an emergency by his younger brother, who has just been involved in a minor accident with the family car. Michael picks up his stranded brother and gets into an argument with the brother's two teenage friends, whom he accuses of responsibility for the accident. Finally, enraged, he pulls out a tear gas pen and attacks one of the boys. He is thereupon convicted of assault and possession of an illegal weapon but, since this is his first offense, is permitted to substitute volunteer community service for the jail sentence. I quote from my student's report:

> "Michael arrived for the first interview neatly dressed and punctual to the minute. He held himself stiffly erect, continually fingered his briefcase and repeatedly looked at his watch. He appeared quite tense and I had the feeling that any moment he would spring from his chair and bolt the room."

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Paper presented as part of an Institute on Dilemma of the Therapist--Practice and Values in a Changing Society, at the 51st Annual Meeting of the American Orthopsychiatric Association, San Francisco, California, April 8 - 12, 1974.

**Since by its very nature this material is difficult to disguise, the reader is asked to treat it in strict confidence.

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Michael was unusually well informed about the nature of the volunteer program and had chosen the Big Brother Organization. He described his choice in a highly rational, matter-of-fact way, explaining that since he had to take a Psych course, this experience might be valuable to him. He expressed little emotion and made no reference to the incident that brought him there in the first place. He agreed to contact the appropriate persons at the Brothers, glanced at his watch nervously, abruptly stood up and, with a polite excuse, left. I quote again from my student's write-up:

> "I caught my breath and reflected on how uneasy and anxious I felt as I listened to and observed Michael. He did not let me near him----he came to the interview with all the solutions. I felt as if I would be intruding into his life space."

This fascinating and rich material was presented in class apropos the topic of affects and affective control. What was so interesting to me, however (and is the reason for my reporting it here) was the trend of the discussion which followed the presentation. I have two Asian students in that particular seminar who were quick to point out that Michael's behavior was quite in line with the traditional Japanese upbringing for a first-born son; they emphasized how the values of responsibility, family honor and shame would be called into play in such a situation. Other class members, accepting this cultural perspective offered by our two indigenous experts, proceeded to "defend" Michael's actions as totally understandable and, therefore,really not of concern to us. Not till much later did it occur to somebody to raise the question of why Michael carried a tear gas canister to begin with -- a critical question if one is to try to understand this young man. Instead, under the guise of empathy and cultural sensitivity and acceptance, the students staunchly defended Michael while keeping multiple psychological questions and issues out of sight. Such empathic postures which tend to "normalize" behavior, simply because it can be understood, are not new. What is new here is that the current (and proper) concern for cultural understanding and its impacts on personality can effect the exact opposite of what is intended; in this case it tended to blur and blunt psychological curiosity and inquiry. Only later, haltingly and with much misgivings, did the group begin to discuss the material from a more wholistic, psychosocial frame of reference, attempting to translate and integrate cultural considerations into psychodynamic, individual behavioral concepts.

This example, which could easily be duplicated and reinforced with others like it, demonstrates, I think, some of our students' dilemmas - in this instance, how to deal with cultural pluralism while avoiding racist attitudes. However, this is only one of our current dilemmas. Others arise from the current broadening of opportunities in our educational system - a value to which I would adhere. This very broadening has altered our student population to a far less homogenous group, bringing with it a multiplicity of value systems into the classroom.

Our students arrive as adults. They enter their training programs with well-entrenched & sometimes unarticulated sets of beliefs and values which validly reflect their unique experiences and backgrounds. For example, four students in our current class who have been in jail, have a rather definite orientation to society's system of rewards and punishments. As the professions have come to recognize their responsibilities towards the disenfranchised, both in providing service and training opportunities, our constituency has become more representative of society at large.

Thus, our students often perceive the world through a variety of prisms, labelled, for example, ethnicity, feminism, drugs, poverty, bisexuality, or the Protestant Ethic. As they come in contact with other, equally dearly-held perspectives, however, and as they begin to rub against each other, an enriched understanding can often emerge. Slow and begrudging acknowledgment that different realities may co-exist, at times complementing each other, and at times in conflict, will develop, if good learning takes place. However, too often these perspectives serve as filters which tend to constrict and impede new learning.

Like "Officer Krupke", our students may turn toward simple-minded and single-minded resolutions.

Musical interlude: "Gee, Officer Krupke" from Leonard Bernstein's Westside Story

* * * * *

Another dilemma, that of the experiential and egalitarian---A colleague reported to me the following incident: Asked to analyze and discuss some material from the point of view of any one of the major theories of behavior, one of his students replied: "Do you mind if, instead, I use my own theory?" The discussion which followed that request revealed not only a rather hazy understanding of the nature of theory and theory construction (that was to be expected), but more importantly, the student's basic affirmation of an existential egalitarianism. It denied any possibility of rank ordering (or other categorization) of levels of ideas, qualities or performance. In essence, this young man questioned why Freud's (or Erikson's or Skinner's) theories are more valuable or trustworthy than his own notions, based on his own life experiences. By implication of course, he also denied his instructor's competence to teach him, or anybody's ability to teach anybody else.

This primacy of direct experience, to the exclusion of other modes of inquiry, is of course one of the hallmarks of the counterculture. Applied to the training of mental health practitioners, it correctly identifies the need for practical field-work as an integral component of such training. The denigration of other, more theoretical ways of knowing, however, which often accompanies this experiential orientation, results in curious learning patterns. Instead of teaching and learning, the classroom becomes a forum for teacher-student "encountering"; since some people find it difficult to encounter books, a complete rejection of reading may ensue. Fortunately I detect a beginning turn away from the dangers and contamination of reading.

Let me turn briefly to the second of the developments mentioned earlier, the fact of the rapid expansion of knowledge in the field of human behavior. Over the last few years both the social and biological sciences have generated a vast amount of new data on all aspects of human life. On the biochemical and molecular level, advances in the breaking of the genetic code, as well as in the biochemistry of learning, promise to cast the nature-nurture controversy into new and more sophisticated terms. At the other end of the life span, studies of retirement, aging and dying have greatly expanded our understanding of this hitherto neglected age range. At the same time, the struggle for minority rights has increased our awareness of economic and political oppression and their effects on human development and behavior. To get a quantitative notion of this rapid expansion, let me just quote from my own discipline the facts that in less than 20 years, the membership of the American Psychological Association has jumped from 14,000 to over 35,000; from less than 300 books annually reviewed in Contemporary Psychology (a journal devoted solely to book reviews) in 1956, the number has almost tripled.

The latter statistic reminds us that, along with this knowledge explosion, there has been a parallel expansion in the media coverage. Who can escape the chronic guilt feelings which are engendered by the continuous bombardment of ads for new journals and books. "Keeping up with the literature" is increasingly a meaningless demand of the professional superego which it is impossible to meet. Indeed, it may be less a matter of "lack of communication" that's troubling us, than too much of it. In this connection, the suggestion by one of my colleagues that, far from encouraging publications, the new Ph.D. not be allowed to publish until at least 5 years after getting his degree, may not be entirely facetious.

What has all this got to do with our students entering the field of mental health? The point is that, unlike the seasoned practitioner who has experience and a measure of criticality to guide him, the novice tends to become overwhelmed by the quantitative and

qualitative complexities of his chosen field. In the face of such anxiety, several maladaptive reactions may be noted: the student may throw himself frantically into the battle, reading haphazardly and at random, in an attempt to cover as much territory as possible. This produces the euphemistically called ""eclectic" orientation which, it seems to me, often shields a rather confused approach to theory and practice. Or, the student may decide, since he cannot do justice to the material, to redefine his interests by prematurely focussing and narrowing them. This reduces ambiguity, tension and dissonance, but at the price of loss of perspective. This is the student who is secure in "knowing what he knows" but who has difficulty broadening this base of understanding. A third, more extreme response is not to read at all, an approach rationalized and reinforced by the experiential stance discussed earlier.

* * * * *

It is not just our students who are bewildered. Struggling with the massive knowledge explosion, and in an attempt to create order out of seeming chaos, instructors too, foreshorten perspectives. Their attempts to standardize, to objectify, and to simplify clinical learning may sometimes so distort the inherent complexity of human experience as to render it almost meaningless. Let me illustrate: one of my colleagues has recently developed a set of "teaching competencies" based on the work of Robert Carkhuff. He requires each student to demonstrate competencies in the following areas: empathy, respect, responsive concreteness, and responsive genuineness. These are called the "facilitative core conditions". In addition, students are required to demonstrate skill in the following action-oriented core conditions: confrontation, appropriate self-disclosure, initiatory genuineness, immediacy and initiatory concreteness. Finally, the student must demonstrate his ability to structure the counseling interview to obtain a "mutually derived counseling contract".

Were I to spend time commenting on the absurdity of such teaching schemes, I fear that I would use the remaining institute time. I leave it for you to judge and to discuss as you choose.

* * * * *

A final set of circumstances besetting our novice professional is the bewildering number of competing techniques of treatment. The easiest way to appreciate the tangle of current systems of psychotherapeutic technique is to attempt a brief listing. With no claim for either order or inclusiveness one can enumerate such techniques as the psychodynamic psychotherapies (with their variants of Jungian and Adlerian approaches), various behavior modification techniques, gestalt therapy, transactional analysis, reality therapy, hypnotherapy, rational-emotive therapy, and primal scream. Going only a bit further afield, one may include the various physical approaches to intrapsychic or interpersonal difficulties, such as massage, rolfing, biofeedback, and bioenergetics, and various schools of sexual training. Morita therapy and other approaches based on Eastern philosophies round out the list.

Only a few of these techniques can claim an articulated theory of treatment of any consequence; notably, the dynamic therapies and the behavior modification techniques. The rest, by and large, reduce the complexities of human psychosocial functioning and dysfunctioning to a set of common-sense variables and then proceed to prescribe equally simple techniques of intervention.

My purpose in presenting the above listing is to convey to you the tremendous confusion which such a therapeutic smorgasbord presents to the novice. The student as yet has no base of theoretical and practical expertise, against which to evaluate each new claim for his professional loyalty. Burdened by his increasing appreciation of the interplay of psychosocial, economic, and political determinants of behavior, he is pushed and pulled by his conflicting recognition of complexity versus his wish for simplification. Since many of these so-called techniques promise expertise overnight, with a minimum of effort, their pull is indeed considerable. In addition, in their rejection of the more established, orthodox methodologies and their emphasis on direct experience, some support our students' ideological stances.

How to evaluate the insights of each of these techniques, how to borrow and adapt for his own use some of them and finally how to integrate the various components into a more or less consistent, workable personal theory becomes a monumental task for our novice, requiring much tolerance for conflict, ambiguity, and tension.

Faced with the array of multiple values, the knowledge explosion and the growing choice of treatment modalities, teaching young clinicians becomes a difficult task, indeed. While the University must remain an open institution where conflicting and varied ideologies can find space, clinical programs must also offer room for coherent, systematic, and rigorous presentations. We can probably agree that we want to produce professionals who are capable of openly evaluating new systems and techniques, on the one hand, but who do not become so innovation-oriented as to be swamped by every fad and fashion that comes along. How to teach consistency without rigidity, coherence without dogma, and flexability without chaos is the central teaching task of our time. It goes to the heart of our values and our dilemmas.

Editorial Note

While the following is not a verbatim copy of the remarks given by William Pierce, Ph.D., many of the points he made are included. In the interests of saving time, we are including this paper presented elsewhere, since Dr. Pierce spoke from written notes.

Shirley Cooper, M.S.
David Orzech, Ph.D.

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THE COMPREHENSIVE COMMUNITY MENTAL HEALTH PROGRAMS AND THE BLACK COMMUNITY

William D. Pierce, Ph.D.

The mood and the atmosphere that exists within the Black community is indicative of a posture of self-assertion, self-direction and self-determination. External manifestations of more deep internal transitions within the Black community should be vivid and clear to those either looking on or directly experiencing the intensity of the Black movement. The contemporary social situation in our country which demonstrates, urban crises, racial discord and an overall moral failure of an old social order in response to Black Americans has generated the demand for change and has given birth to new, more relevant ideology. New ideology and demand for change along with social action is a response of a people--a people committed to change.

The reaction of the American majority to this Black posture ranges from defining the direction of the Black movement as realistic self-determination, to cultural pluralism, to polarization, to separatism, to, and by some strange, esoteric logic--reverse racism. However seen and defined, the changes are real and are indicative of meaningful departure and growth from previously established patterns. Social change, social action are the reality and the necessity.

If comprehensive community mental health services in the Black community are going to be, indeed, part of the community that they serve, if community mental health programs are to be, indeed, community relevant, then the transitions taking place within the Black community have important implications and agendas for these programs.

Let us then focus our attention, briefly but seriously, on the role of comprehensive community mental health programs within the Black community in terms of the social-environmental-attitudinal context in which services of whatever nature are provided.

ATTITUDES CONCERNING MENTAL HEALTH

When thinking about, and attempting to make some sense out of mental health and the Black community, one is confronted with the task of unraveling and isolating numerous variables that interact with each other. On the one hand, there are variables that are operative within the Black community, and on the other hand, there are variables operative in the provision of mental health services. In terms of the community mental health approach wherein a basic tenet is to take into consideration that behavior is a function of the individual and attributes of his environment, his milieu, his community, the complexity of the interaction of many factors become unavoidably more clear and one must maintain a healthy respect for these complexities.

Let me first comment on the community's attitude and operative definition of emotional disturbance or mental illness. Though generally

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throughout the society there is a negative value attached to mental illness there appear to be some specific factors operating in the Black community which further influence the already functioning negative attitude. It is a common opinion that the Black community tolerates or absorbs a greater degree of "deviant" behavior. Because of the multiple problems that exist and are perpetuated, the community has adjusted to a certain level of chactic and socially disruptive behavior. Hence the expectable environment is defined by a greater degree of disruptive activity. Thus behavior that is considered disturbed or "crazy" would have a greater disruptive intensity in order to be viewed as outside of the norm or abnormal. So for the community or agents in the community to recognize that something is wrong with someone and to react to them, the behavior has to be visibly bizarre or the functioning severely impaired. A result is that being mentally ill takes on the negative and threatening connotations associated with a crisis situation. Another result is, as some studies have suggested, that Black people clinically appear more acutely or severely disturbed on admission to a psychiatric facility (Dreger and Miller, 1968). This finding leads the naive observer to a false conclusion--that Black people become more sick or are more severely disturbed. The issue is, at what point within the community is mental illness recognized and at what point is there contact with a treatment facility. Take for instance a person who indeed may be severely depressed, not communicating much, not active, or not working. Because it is not unusual within the environment to be out of work and inactive, the person is not highly visible until his symptoms become so severe or his functioning becomes so impaired as to be disruptive or such a burden on those who may be caring for his needs; he remains unnoticed and therefore untreated.

The traditional lack of availability of psychiatric services and the lack of exposure to knowledge about emotional disturbances of course are in large part responsible for this state of affairs. Needless to say, the state of affairs, remaining unnoticed and therefore untreated, presents a somewhat unique but indeed important problem that must be dealt with, especially in the design of effective programs of primary and secondary prevention; that is, minimizing the causal factors of emotional and mental disturbance and the early recognition and early treatment of disturbances once they do occur.

Another important factor influencing a negative attitude toward mental illness is in a majority of cases the agent who intervenes and is responsible for making contact between a disturbed person and a treatment facility is a policeman, social worker, welfare worker, school counselor or teacher--in short a member of the "establishment." The intervention many times results in a court commitment to a hospital. The implication is a punitive, oppressive, discriminatory situation where Black folks are involuntarily taken and put away in terrible places.

It is realized of course that there is reality to this implication many times. However the point is, that this phenomena influences a negative attitude toward not only mental illness but the treatment of mental disorders. Comparative studies of different racial groups validate

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this attitude of Black people. Once admitted to an inpatient psychiatric facility, mainly state hospitals, Black people are kept longer. They are not released at a comparable rate as whites and final release rates are lower than for white patients. However, when Blacks are released, they are received with more support and acceptance within the Black community than white ex-patients are within the white community. But, Black ex-patients are accepted much less when the overall social structure is taken into consideration (Maas, 1967). Thus, in the society at large, in other words outside of the Black in-group, Black ex-patients not only have the negative stigma of an ex-mental patient, but by being Black in a racist society all of the indignaties, insults, and limitations inherent to the racist system must be dealt with also.

Finally, in regard to attitudes about treatment, the relative importance of the role that religion plays in the Black community deserves comment. The position or point of view that one's suffering is a result of or in large part, a result of his sinfulness or evilness, or that one is "full of the devil" suggests that one's suffering has come out of something he has done or has not done, and thus, provokes guilt and designates blame for one's suffering. Likewise, the position that one's suffering is only alleviated by getting to the Promised Land can be interpreted to mean that nothing can actually be done. I by no means intend to be sacrilegious or point the finger at the Church, for certainly it has been a major therapeutic and survival force in the Black community--there when nothing else was there, or cared enough to be there. Nevertheless, the factors I have mentioned are found to be operative.

Again, these variables that I have briefly commented on are by no means comprehensive and all-inclusive, but are some that appear to be of relative significance in terms of the Black community and community mental health.

COMMUNITY MENTAL HEALTH PROGRAM AND SOCIAL ACTION

A community mental health program that exists within a Black community and that provides services to a Black community, on the basis of where and why it exists, should be functioning as a social action program. In both direct and indirect services, social change--relevant social change--has to have the same priority and the same sense of urgency to the program as it has to the people of the community which it serves.

Black people are in the process of changing their state of affairs and hence the Black community is in transition and is changing. Therefore, institutions and programs in the Black community are inextricably connected to and involved with this change. This is particularly important for community mental health programs in terms of the broadening definition of mental health and its broadening arena of responsibility. From pre-natal care to child development, through education, housing, employment on to concern about our senior citizens there are variables, issues and problems that fall within the community mental health program's "conceptual catchment area." This "conceptual catchment area" reflects the battlegrounds of social action and change within the community.

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The important aspect is a particular program's relationship with the change in the community. What stances does the community mental health program take in reference to change? Several alternatives come to mind:

1) The program can stand in either covert or overt opposition to change, resisting innovation and attempting to maintain the status quo;

2) The program can maintain a stance of cautious neutrality; a "don't rock the boat mentality" that directs the program to just be cool and wait until the dust settles so it can be sure of what hook it should hang its hat on;

3) The program can stand in support of and in sympathy with change but does not actively participate in any social action to bring about change; or

4) The program can be part of the dynamic processes of the Black community, an active, assertive and aggressive participant in social action, an active part of the Black movement.

This last stance is the only justified relationship between a community mental health program and the Black community. It must exist as part of the Black movement; it must be committed to social action and change.

Being part of the movement requires that the mental health program have a functional relationship with those elements of the Black community that are operating as mechanisms and vehicles for change and social action. Community Action programs, Headstart programs, Upward-Bound programs, skill and job development programs, housing programs, and various other programs that deal with youth, education, employment, job training and police and legal problems are examples of operations that are attempting to implement change. I am not merely referring to the traditional "War on Poverty" and "Urban Crisis" programs but also to the various independent Black organizations and groups within the Black community that have been born out of the womb of the Black revolution. These programs and organizations are down front attempting to deal with the social problems and social issues that are relevant to Black people. They are struggling with the problems and issues that make up the intolerable state of affairs that the Black community is revolutioneering away from. Not only are these programs, groups, and organizations concerned with change but they are concerned with removing and eliminating factors that cause and perpetuate the unnecessary human suffering that has been imposed upon Black people. Hence these groups, organizations and programs operating within the Black community are not just curative and/or remedial but they are also preventative; they are concerned about making sure that the future will not duplicate the past--that Black tomorrow will not be like Black yesterday.

Essentially this discussion has to do with the general mandate that community mental health programs be relevant to the community and be responsive to the needs of the community that it serves. It is important

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to realize and understand that basic to being relevant and being responsive to needs of the community, the mental health program must maintain the same philosophical posture and orientation of the Black community. The mental health program must act out of the same framework that is existent in the Black community. The mental health program and the Black community must be "coming out of the same bag." A primary prerequisite is that the mental health program and the Black community have their "heads in the same place." The actions and reactions to each other must be syntonic. This primary prerequisite should be fulfilled as the initial response and commitment of relevancy to the Black community and if not conflict should be expected.

If this initial and basic need is sincerely fulfilled then direction and clarity is given to the manner in which the other mental health needs of the Black community are met, not only in the indirect services subsumed under primary prevention as discussed above, but also in the provision of direct services (inpatient, outpatient, partial hospitalization and emergency).

Needless to say, one of the overwhelming needs in the Black community is the increase of the quantity and the quality of direct services. The Black community is concerned not only with having more mental health services but it is concerned with the quality of services rendered and that these services be relevant in both content and style of delivery. As mental health professionals we generally are aware of the need to provide services to those segments of the population which have previously been denied or shortchanged. Yet there are problems with the quality of services which we seem reluctant to attack and which are important to the Black community specifically.

The issue which I am about to deal with was touched upon in the June, 1969 edition of the American Psychologist by William Schofield in his article, "The Role of Psychology in the Delivery of Health Services." He recognizes the need by writing "...current concern is with the establishment of mechanisms to assure that no segment of the population will be without access to adequate health services. This effort involves two components: creation of a sufficient pool of skilled health personnel and assuring that their services are made efficiently available to the public." With this important recognition of need that should lead to an arrangement of priorities, Schofield lays bare the painful truth. He reports that in a survey of 19,027 psychologists nearly two-thirds saw their service as related to the field of mental health. Schofield reports, and I quote, "Of the clinical and counseling specialists, only 41% and 33% respectively, reported engagement in direct service as their primary (not necessarily full time) activity. Of the total sample of psychologists, only one-fourth are primarily engaged in direct service activities as clinicians or counselors.

"How are these figures to be appraised? They indicate that a majority of American psychologists see their primary activities as germane to at least one sector of health, that is mental health. They reveal that an appreciable but very much smaller number are engaged in rendering direct clinical services to people with problems."

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The article goes on to suggest: "The more socially oriented psychologist may feel that we are making an insufficient contribution to the psychological needs of the population if less than one-half of the clinicians and counselors report direct services as a primary activity."

Regarding the Black community's demand for an increase in relevant, skilled and quality services this is most definitely an understatement. As mental health professionals let us try to be more honest about what is happening in terms of service in many of the "high risk areas," which is the new term that connotes the Black community. In too many instances university departments and medical center complexes are utilizing their students and trainees of the mental health professions to provide services to the Black community and feeling satisfied, that they are making a significant contribution. It is a community or social action orientation, but only for the students and trainees who have the minimal experience and skills, not for the professionals who do have needed expertise and skills, who send the trainees. Indeed we need to increase the number of mental health professionals and this means training of personnel. Yet it becomes an important issue when we only use students and do not make available to the Black community the maximum skills and expertise available, and this means the professionals that do exist. It is also an important issue for the Black community when it realizes the paucity of Blacks that are among this student and trainee contingent. It is important in view of the need for quality and relevant services in the Black community. I daily face this issue in the community mental health center where I function. Not only is the need for quality services demonstrated but also the Black orientation, when increasing numbers of Black brothers and sisters walk in seeking to talk with a Black therapist. When they ask for Black they mean Black and when they ask for a therapist they expect to talk to a skilled, relevant and experienced professional. It is going to take time to increase the numbers of Black mental health professionals. But we can do more when it comes to providing the community with the most experience, skills, and expertise that

We cannot, either be satisfied by attempting to resolve the demand for Blacks by merely increasing the number of indigenous non-professionals. Although this is an important step the role of the indigenous non-professional has limits and in many respects perpetuates old inequities because employment-wise it is a low entry level job with low power and no mobility.

The issue and the sad fact of the matter is that in too many Black catchment areas most of the direct services provided by the community mental health program are being rendered by pre-professionals or non-professionals, that is by psychology interns or students, psychiatric residents, social work trainees, and by the indigenous personnel. This means that direct services are being rendered to the Black community by those with the least amount of professional experience and expertise. Though the indigenous personnel may stay when the trainee or student, who is usually white, completes his training and gains professional status, he keeps right on stepping out of the Black community to return later as a consultant, supervisor or possibly an administrator. He returns in a capacity that does not provide direct services. Meanwhile, the quality of

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direct services offered the Black community does not change. This is exploitation!

In community mental health we are going to have to make better sense out of the training-service issue if we are going to respond to the need of the Black community for quality direct services. This means we are presently going to have to make better sense out of the use of the professionals that we now have. Just as the philosophy of the Black community points out, we are going to have to change. Surely, as the Black community becomes more exposed to the mental health area there will be heightened concern with the quality of professional services offered.

As Schofield's article shows, too many psychologists with clinical skills and training are not making their skills available. I think an outmoded criteria of professionalism is in part the cause. Unfortunately professional progress is now measured in the direction of supervisory or administrative type positions. These positions carry with them more professional prestige, authority, and compensation--things which certainly appeal to all of us. Nonetheless, attaining one of these positions usually means that one is giving less and less direct service, the very thing in the Black community that is needed most. It just does not make sense for those professionals who are providing direct services to have less professional authority and to receive less compensation in the program in which they serve. Independent of who the directors or administrators are or what their talents may represent, the effectiveness and success of a community mental health program is dependent on the quality, level, and scope of the services it provides. We, as Black people, cannot afford to continue this subtle but strong orientation away from the most urgent needs in the mental health professions. If we do--in the Black community--we are going to find ourselves in conflict with the community.

In conclusion, let me state again that community mental health programs and the Black community are going to have to be "coming out of the same bag." The actions and reactions to each other must be syntonic. If comprehensive community mental health programs are to be an integral part of the dynamic social processes of the Black community, then they must immediately begin to acknowledge the validity and seriousness of the "Black Phenomenon" and not only be directed by it but be encouraged to participate and function within it.

The response to inequity and deprivation is a move for power, control and self-aquisition; the response to submission is a move for autonomy; the response to resistance is further alienation, rejection and conflict; the genuine commitment to social change is a response of ACTION.

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THE ROLE OF THE THERAPIST IN PRISONS

Frank Smith

Prisoner's Union
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A paper presented at the American Orthopsychiatric Convention in San Francisco, California, April 9th, 1974.

I am pleased that the AOA has seen fit to listen to the concerns of prisoners with regard to their perception of the state of the "therapeutic" art in prisons. No doubt some of what I have to say today will rub some of you the wrong way. I urge you not to lightly dismiss our feelings and recommendations; not to ignore us as another co-opted minority which can conveniently be patronized and forgotten. To do this would be to the detriment of the therapeutic professions, society in general, and prisoners in particular.

It is our contention that "therapy" as it is presently almost universally practiced in prisons, is nothing but control at best, and torture at its worst. This thesis is probably not new to any of you, having been thoroughly publicized in the popular press, most recently in Time magazine on March 11th. A number of our colleagues have thoroughly documented the abuses of the therapeutic arts in total institutions, some of whom, such as Peter Breggin, Lee Coleman, Ned Opton, Henry Steadman, and Bernard Diamond, will be addressing this convention. Today, however, we hope to present some newer views on the situation, and specific recommendations for change.

In his article, "The Psychiatrist as Double Agent," I believe that Dr. Thomas Szasz has struck at the heart of the matter. Dr. Szasz directs himself to the question of the politics and ethics of the university psychiatrist, but I believe that the analogy can be extended to all therapists and counselors who work in total institutions, such as, the military, mental hospitals, and of course, prisons.

Dr. Szasz, after a discussion of the political nature of therapy, identifies the problem as a function of the nature of the relationship of the patient and therapist; rather than being a contractual relationship, in which each party has obligations and rights, it is a "status relationship, characteristically hierarchical, as in the relationship between master and slave; the inferior member of the pair has little or no power to restrain his more powerful partner."

This relationship corrupts the therapeutic process. Any element of advocacy or confidentiality is destroyed. The perceived client becomes the State, rather than the prisoner, and the therapist is the enforcer of social sanctions. The cloak of the "helping professions"

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is used, however, to obscure this fact from the convict. It is intimated that the discourse is subject to the same protections as are those with a lawyer or priest. The spied upon convict pays dearly for his naivete.

The above relationship may be clarified by reference to a recent occurrence in the California prison system. When a patient in therapy stabbed a prison official, the guards went to the office of the prison psychiatrist, and there demanded his clinical notes about the patient's psychotherapy.

When the psychiatrist refused, he was forcibly restrained while his files were rifled, and the case file was removed, and then he was ejected from the prison grounds. When this doctor persisted in efforts to maintain the right of the client to confidentiality, the Department of Corrections attempted to frame him on criminal charges, in order to discredit him. The incumbent Attorney General of the state of California subsequently delivered an opinion that the "client" of the "therapist" was the State, not the prisoner.

I'm sure that you're aware of some of the abuses that this sort of relationship engenders. The state of California seems to have led the way, along with the Federal Government, in perverting the ideals of the therapeutic professions. It has originated reality therapy and massive "group counseling" which are administered by guards, on a forced basis. It has used aversive conditioning with Anectine, Skinnerian operant conditioning, electroconvulsive "therapy" and transactional analysis, and even psychosurgery, most of which has been done in the absence of consent by the prisoner or his family.

At the present time, California, which has the third largest prison system in the world, plans to build two new 2,400 man prisons, at a cost of $70,000,000 each, one of which is already designated as a "psychiatric" facility, and the other of which is being built next to an existing facility of similar purpose. In the past, this prison has been the scene of the worst psychiatric abuse and medical experimentation in the country.

The technique of ECT is frequently used in the prison situation. This is in spite of the fact that evidence indicated that shock is responsible for non-ECT seizures, retarded coordination, retrograde amnesia, reduced concentration and attention span, impaired learning, long term confusion, longer hospitalization, lack of response to psychotherapy, and eventual ablation of the limbic system of the brain. Indeed, research indicates that those patients most likely to get shocked are those who get along least with their doctors. We should end this practice.

The therapist in prison is responsible for a great variety of abuses. At the least, he provides window dressing for a coercive and violent situation. He may also design these coercive programs. Finally, he may just "carry out the orders" of the prison administration in treatment and classification. He is no less responsible for these abuses than was Eichmann who used the same defense.

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Because of the cultural and economic gap between the typical prisoner and his "therapist" it is quite unlikely that any therapeutic rapport may develop. The problems of this gap have been explored by such social psychologists as Joseph Luft and D. & B. Braginsky. It is quite unlikely that therapists will ever be much good in prison, unless they are somehow filled with the middle class. Dr. Jerome Frank has noted that people cannot be helped by those that they do not believe in, and the poor and the ethnic minorities that fill our prisons are not noted for being a vast reservoir of believers in our trade, even though, with reference to the studies of Hollingshead and Redlich, it's mostly they that are stigmatized as "crazy."

A psychiatrist or other therapist in prison must reconcile him or herself to the fact that they are perpetuating and helping to expand, an incredibly oppressive system. Therapists cannot look the other way, avoiding the evidence of their eyes and statistics, that the majority of our prisoners are not white. They must come to terms with the fact that most people in prison are not dangerous, and, in fact, most persons are in jail for non-victim crime.

I am not suggesting that we eliminate all therapy from prison. What the Prisoners Union wants is a basic restructuring of the relationship between therapist and convict.

Because of the indeterminate sentence system in California, most men and women in prison cannot freely consent to enter into therapy, and this system is used in approximately forty states.

We suggest that those of you at this convention take an interest in what's happening in your prisons; you pay for them. Working toward access of the public to prisons would be a step in the right direction and helping to oppose the supposedly "therapeutic" indeterminate sentence, another.

You can demand that the State not hire your colleagues for prison work, and apply organizational pressures to get those who are currently involved, out of prisons.

In their place, convicts should be allowed, at State expense, should they desire therapy, to contract with individual therapists for services. If they don't like the service that they are getting, they can place their business elsewhere. The fact that they are in or out of therapy, should not affect the time they stay in prison one whit, in order to insure they are in therapy for what the therapist can offer to a free person. The above system would be cheaper than the present one, and would be a great deal more ethical.

We can only have this kind of change if we all work for it, and those who don't are guilty of perpetuating the present mess, to the detriment of themselves, the professions, and the prisoners.

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Annual Meeting of the American Orthopsychiatric Association

Institute: Dilemma of the Therapist-Practice and Values in a Changing Society

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I would like to center my remarks today around the challenges to psychodynamic psychology -- known today as "traditional psychology" -- especially as it relates to community mental health practices. Though I speak as a clinical psychologist and as a trainer of psychologists, I believe that many of the problems and issues I will be discussing apply as well to other mental health professionals.

As a starter, I would like to address myself to some of the not unfamiliar questions raised at a recent national conference on the training of clinical psychologists. In discussing training in community psychology, some of the following questions were raised:

> "Are traditional skills obsolete, perhaps even obstacles in the way of good community training?...what can be retained and what must be dismissed as irrelevant?...Indeed, how helpful are traditional notions about psychopathology? Is it possible for us to meet national and professional trends without throwing away the hard-earned knowledge of the intra-psychic, of the importance of what happens within the individual?"

What are some of these national and professional trends that suggest we "throw away the hard-earned knowledge of the intra-psychic, of the importance of what happens within the individual?"

For many years now the National Institute of Mental Health has been the voice of the major trends in mental health in this country. Sometimes the originator, more often a reflector of what is happening in the field, and up until recently the major implementor and funder of programs, NIMH has suggested specific program priorities. In recent years, NIMH included two major priority areas which in my mind implicitly suggest movement in the direction of primary prevention, early intervention and new and innovative programs:

> First, Child Mental Health: not just clinical but child advocacy; day care centers, concentration on schools and pre-schools, and
> Second, Special Problems: such as drugs, alcohol, crime and delinquency.

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In my view such program priorities constitute no particular challenge to traditional clinical knowledge. If there are those who see such priorities as a challenge, then I think that they are operating on two false and related assumptions. One assumption is that theories of psychopathology exist separate and distinct from theories of personality and personality development, and that clinicians are bounded by a narrow and distorted point of view which addresses itself to only the inner and abnormal life of the individual. This "boundedness," they assume, prevents clinicians from recognizing social, cultural, and ethnic realities. I think for the most part such false assumptions are directed toward psychoanalysis and other psychodynamic theories and represent a complete misunderstanding as well as a distortion of these theories. I believe it would be inappropriate for me to dwell on this topic today. But let me just state that I believe it is categorical

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nonsense that these theories confine themselves to the inner and abnormal world of the individual. Freud's lopsided emphasis upon the internal life of the individual has been challenged and corrected for by a host of theorists and practitioners who came after him (Sullivan, Horney, Fromm, Erikson, to name a few).

In challenging traditional psychology, there is a second and related false assumption which is frequently made and that is that clinical knowledge and theory, since it is based upon individual psychology, is equated with a treatment modality that is exclusively individual psychotherapy. The theories which clinicians use are essentially designed to understand human behavior and as such can be applied to a wide variety of problems and in a wide variety of ways. An understanding of individual psychology does not preclude programs in advocacy, prevention, early intervention or in consultation; it does not preclude work with families, with groups, with institutions or with the setting up of new and innovative programs. Clinical understanding, in fact, is an enormous help in enabling us to design programs, preventive and otherwise, in and outside of our offices. In our Department, for example, we used our theoretical knowledge about human behavior in an attempt to help alleviate parents' and childrens' anxieties about enforced school busing in San Francisco. We designed a program in which we placed a professional staff person on a school bus to ride to and from school with grade school children; in addition, this staff person had streetcorner meetings with the parents about their busing concerns, and, also, acted as their advocate to the schools. As for the children, knowing the children would be experiencing separation anxiety in this normative life crisis, we had our Hospital Art Department design coloring books with maps of the territory they would cover on the bus route; we attempted to introduce play materials and games that would be helpful to the children. encouraged the children to carry "transitional objects" from home on the bus such as dolls, teddy bears, special favorite toys. Our staff member met with the children before they boarded the bus, talked to them on the bus, and again in their new schoolyard and on the way back home again. There is no doubt that our traditional theories of personality provided the moving force in this program, and that the program was based upon our knowledge of child development and normative life crises.

About advocacy: is knowledge of the individual an obstacle in the way of advocacy? I think not. While the mental health professional has too often been timid and overly cautious in contributing his knowledge and leadership to community action, I do not think such action is inimical to his clinical commitment. We, at Mount Zion, for instance, have been advocates for years -- long before the Joint Commission on the Mental Health of Children suggested it as a legitimate area of concern for mental health professionals. I could tell you of our efforts to organize and coordinate community people to effectively influence archaic practices at Juvenile Hall, of our effort -- partially successful -- to establish an Office of Children's Services in the Office of the Mayor designed to plan and coordinate comprehensive health services for the children of San Francisco. I could go into detail about our work -- as professionals -- with the Neighborhood Legal Assistance Foundation which eventuated in helping to expand school programs of free breakfasts and lunches; we were there when Reagan threatened Medi-Cal cuts, and more recently protested cuts in community mental health services in our City's budget!

The point I am making here is not that it takes clinical knowledge to organize such community efforts -- far from it. My point is that clinical knowledge not only does not impair our ability to move toward advocacy of all kinds, but as importantly, in many instances this same knowledge motivates us strongly to take action and enables us to make informed judgments as to the points at which

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interventions are necessary. For clinicians know only too well and often too painfully the impact of unjust and unfair systems and insufficient services on the day to day lives of those we see in a variety of settings and services. Clinicians do not live in the ivory room that some people imagine, seeing a patient at a time. It is a myth that clinicians by virtue of their training are deaf to the influences of political organizations and other forces upon the mental health system. In fact, I would say that the clinically trained, perhaps more than most, have the kind of intimate knowledge about people and the impact of the system upon them that is needed to know where and what kinds of social action interventions should take place.

But here I would differ with many in community mental health who believe that primary prevention in the form of social action advocacy should be the major thrust of the mental health professional working in the community. I think I have made it clear that I believe that social systems effect the mental health of people. And if I have not made it clear, I believe that prevention in the form of consultation to systems, in the form of new and innovative programs, in the form of basic research, and in the form of social action are all legitimate concerns for mental health professionals. But I do not believe in the imperialistic notion that social action is the sole or major role of <u>all</u> community mental health professionals. My concern here is that the "social action-only" advocates are dismissing the current mental health needs of the disadvantaged that can be helped, that they are writing-off an entire generation of those who cannot afford mental health care -- and that includes the middle class as well as the poor. I think there is a danger that the net effect of the social action-only position will be to deflect a significant portion of the mainstream mental health manpower pool into the dry creek bed of political frustration and lead to a depletion of mental health care of such proportions that the disadvantaged and unprovided once again have only the choice between second or third rate services or none at all. And even assuming that the social actionist were successful, there is every reason to believe that psychological problems will persist even after social change. In addition, I believe that our major know-how and as a consequence our major job as mental health professionals lies in the provision of mental health programs and in the devising of any necessary and new ways to facilitate the use of programs. I am hard put to see that primary prevention in the form of eliminating or correcting the harsh environmental conditions related to mental illness is within the armamentarium of the mental health professional. If anything, in fact, our effectiveness as advocates most often lies in the very fact that we are experts in our own field and can lend our credentials, our prestige, status, and, most importantly, our detailed knowledge to the fight. But to shake the system, to provide adequate housing, enough jobs, good schools, destroy racism, break up the military-industrial complex in this country -- for that's what it will take -- for that, for all that, what does the mental health professional have to offer? God knows, if there <u>are</u> those of us who know how to do it, it's criminal that they haven't let the rest of us in on it!

Related to the false assumption that our traditional skills and knowledge are equated with individual one-to-one psychotherapy alone and antithetical to other sorts of activities, I think there is a second false assumption widely held, both by those who support and those who oppose community mental health trends. There are many who would believe that community mental health itself defines and delimits the kinds of mental health services offered. I have heard over and over again that one-to-one psychotherapy is "out," that it is irrelevant, antique -- and worse. Community mental health, I believe, is a mental health delivery system designed to provide mental health care to the unprovided. It is not a particular treatment modality; it does not define and does not delimit the modalities to be used. In addition, while I value new and innovative programs, I am hard put to see how traditional clinical skills including one-to-one psychotherapy can be avoided

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in view of the Community Mental Health Act of 1963 which declared that Centers must include in-patient, out-patient, consultation, day treatment and crisis services. And I would go further and maintain that there is no data to support the idea that the poor in this country have any less need for those equipped with traditional skills than the rich. In fact, I would say that they have the right to the kind of expertise that the upper middle and upper classes in this country have had for years.

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While I have thus far concentrated my remarks upon the need for traditional clinical skills in community work, I do not mean to imply that this is the only prerequisite for the community mental health worker. Indeed, I believe that there are areas of expertise, long neglected by the mental health professions, that are essential to effective community work. Perhaps these areas are best summed up by the phrase "Getting to Know the System." And, by this, I do not just mean exposure to systems theory or formal organizational charts. I am reminded as I talk of this, that I have often thought that an administrative psychologist -- or any administrator for that matter -- has a great deal to teach a community mental health professional. It took me a good number of years as Chief Psychologist at Mount Zion to understand that there were things other than psychology that I had to know. At first I kept thinking that those "other things" were nuisances and kept me from doing my job, my <u>real</u> job -- psychology. But eventually I was faced with the fact that those "other things" in great part <u>were</u> my job. I'm talking here of getting to know the system and the personalities within the system, the knowledge of where power lies, both apparent and real, how to wheel and deal with that power, when to use what channels and when to avoid others, politics within my own Department, in the Hospital, and beyond the Hospital, overt and covert agendas, issues, pseudo and real, when to fight and when not to fight. These were things that I, as administrator, felt I had to protect our trainees from -- and often staff as well. Well, I have changed my mind. This is the stuff of which the real world is made and if you want to develop programs, offer services, and in general be effective, this is the stuff you must know. And this is the stuff we must teach, both didactically and in the field.

Yes, I am committed to the notion that there is much for the community mental health professional to know, both old and new: I believe he must have sound clinical knowledge and competence as well as an intimate knowledge of the social contexts in which he works. There is no royal road to such knowledge. That road is paved with hard work and experience, and it takes a long time to get down it, and even then there is no end. Speaking as an educator, it sometimes worries me that the national trend in this country seems to be going in the direction of shortening training and training people at the lower ends of the educational scale to work in the community. While I have no argument with this trend, and in fact applaud it, I am concerned by the concurrent trend of deemphasizing training at the higher levels. I speak as an elitist when I say that there are vast numbers of poor and of those to whom mental health services were not available in the past, and in my judgment, it is time they have the best that this country can offer. As a black psychologist friend of mine once said, "Would you let your sister go to a para-professional for therapy?" It seems natural to go on from here to discuss the need for highly trained minority professionals, but I will leave that to Dr. William Pierce who will probably be touching on this topic tomorrow. Instead, I would like to end on a note and a plea that our long-learned and hard-earned knowledge of what goes into the making of a community mental health professional be not disavowed in the nation's rush toward new and innovative ideas. I go not kicking and screaming into the future. But I would like to take with me some of the old as I gather also new insights and new ways of looking at things.